City of Roswell, NM

P.O. Box 1838
Roswell, New Mexico USA 88202-1838
(575) 624-6700
Fax: (575) 624-6709

NOTICE OF INTENT TO USE FAMILY AND MEDICAL LEAVE

Printed Name: _____ SSN: ___ - ___ - ____

Mailing Address: _____ City: _____ State: _____ Zip+4: _____ - _____

I request Family and Medical Leave in accordance with Rule 712.2 and Rule 712.3 of the *Personnel Rules and Regulations*. I understand that my leave is subject to Rule 712.0 - 712.6 and other applicable rules of the *Personnel Rules and Regulations*.

Start Date of Anticipated Leave: ☐☐-☐☐-☐☐

Expected Date of Return to Work: ☐☐-☐☐-☐☐

Type Leave Requested: ☐ All Available ☐ Sick ☐ Annual ☐ Unpaid ☐ Personal/Floating Day

Reason for Family and Medical Leave (check one):

☐ Birth of employee's child, placement of child for adoption or foster care.

☐ Serious health condition affecting your ☐ spouse, ☐ child, ☐ parent for which you are needed to provide care.

☐ Serious health condition that renders you unable to perform the essential functions of your job.

I understand that my request for family and medical leave based on my own serious health condition or the serious health condition of my spouse, child or parent shall be accompanied by the required City of Roswell "Medical Certification Statement" (pages 1 and 2) of this application from the health care provider.

I understand that if I fail to return to work at the end of family and medical leave I may be subject to dismissal in accordance with Rule 809.0 unless an extension has been agreed upon and approved by my department head and City Manager.

I hereby authorize the City of Roswell to contact my health care provider to verify the reason for my request for family and medical leave or for any other information concerning my request for family and medical leave.

MAKE SURE THE CITY OF ROSWELL "MEDICAL CERTIFICATION STATEMENT" IS ATTACHED, if required

_____ _____
Employee Signature Date

☐ Eligible ☐ Not Eligible

_____ _____
Human Resources Director Signature Date

☐ Approved ☐ Disapproved

_____ _____
City Manager Signature Date

CITY OF ROSWELL, NM

RELEASE OF HEALTH INFORMATION - FAMILY & MEDICAL LEAVE

Note: Under HIPAA's privacy act rules, an authorization obtained from an employee allow's the use and disclosure of protected health information (PHI) both by the covered entity requesting the authorization and a third party. It must be written in specific terms to all PHI use and disclosure for purposes other than those of treatment, payment and health care options (TPO).

I, _____ [employee's name] hereby authorize the use or disclosure of my health information as described in this authorization.

(1) Specific person/organization (or class of persons) authorized to provide the information:

_____

(2) Specific person/organization (or class of persons) authorized to receive and use the information:

A representative of the Human Resources Department or City Manager or designee

(3) Specific and meaningful description of the information:

FMLA

(4) Purpose of the request: *(Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual.")*

"At the request of the individual"

(5) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by notifying the Human Resources Department in writing at P.O. Box 1838, Roswell, NM 88202-1838 or at 425 N. Richardson. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(6) I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.

(7) I understand that approval of my request for Family and Medical Leave Act leave with the City of Roswell may be conditioned on my agreement to this authorization, and any additional authorization the City of Roswell requests.

(8) I understand that I am entitled to receive a copy of this authorization.

(9) I understand that this authorization will expire when my employment with the City of Roswell terminates.

_____ _____

Printed name of employee Signature of employee

_____

Date

Personal Representatives Section

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of : _____

MEDICAL CERTIFICATION STATEMENT

(Family and Medical Leave Act of 1993)

Page One

1. Employee's Name: _____

2. Patient's Name: _____

3. Diagnosis: _____

4. Date Condition Started: _____

5. Probable Duration of Condition: _____

6. Regimen of treatment to be prescribed. (Indicate number of visits, general nature and duration treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day of days per week.)

_____

_____

_____

a. By Physician or Practitioner: _____
(Printed Name)

b. By another health services provider, if referred by Physician or Practitioner:

_____
(Printed Name)

PLEASE PROCEED TO PAGE TWO.

MEDICAL CERTIFICATION STATEMENT

(Family and Medical Leave Act of 1993)

Page Two

For certification relating to the employee, please answer questions 7 and 8.

7. Is the employee able to perform work of any kind other than essential functions of the position?

☐ Yes ☐ No

Type Work: _____

8. Is the employee able to perform the essential functions of his position? (Please answer question 8 after reviewing the employee's job description, speaking with the employee or his supervisor.)

☐ Yes ☐ No

Comments:

_____

_____

_____

Health Care Provider's Signature Date

_____

Health Care Provider's Printed Name and Address

For certification relating to the employee's family member, please answer questions 9 and 10.

9. Does, or will, the patient require the assistance of the employee for basic medical, hygiene, nutritional needs, safety or transportation or psychological comfort?

☐ Yes ☐ No

10. Please estimate the period of time the employee will be needed to care for the patient.

_____

_____

Health Care Provider's Signature Date

_____

Health Care Provider's Printed Name and Address

NOTICE OF INTENTION TO RETURN FROM FAMILY AND MEDICAL LEAVE

I, _____, hereby submit my "Notice of Intention to Return from Family and Medical Leave". I understand that my return to work shall be in accordance with Rule 712.5 and other applicable rules of the *Personnel Rules and Regulations.*

Date Leave Started: _____

Date of Planned Return: _____

_____

Employee's Signature Date

I certify that _____ is fully able to return to work.

_____

Health Care Provider's Signature Date

_____

Health Care Provider's Printed Name and Address

EMPLOYEE TO RETAIN UNTIL RELEASED TO RETURN TO WORK